Renewal Date: _____

Montana Department of Labor & Industry

Employment Relations Division, Workers' Compensation Regulation Bureau
Street: 2201 White Blvd.
City/State/Zip: Butte, Montana 59701
Phone: (406) 494-0310 Fax: (406) 494-5481 Email: bwheeler@mt.gov
Website: http://erd.dli.mt.gov/wcregs/selfinsure.asp

Date Stamp – Office Use Only

Workers' Compensation Self-Insurance Application for 2010

Complete this form in its entirety. Unanswered questions may delay processing.
Refer to the related instruction sheet on the above web site for details.

Check One: ☐ New ☐ Renewal ☐ New member of existing group
Group Name: _____

If new, proposed effective date of self-insurance coverage: _____

GENERAL INFORMATION

Name of Company: _____ Date Established: _____
Date Company Started Business in Montana: _____
Address: _____ Federal Employer Tax ID #: _____
_____

Parent Company: _____ Date Established: _____
Address: _____
_____

Montana Operations (continue on separate sheet if necessary):

Legal Name	Number of Employees	Location	Nature of Business
1			
2			
3			
4			

Total Number of Montana employees _____
(Number of W-2's plus Volunteers) Gross Montana Annual Payroll for CY 2009 $_____

Company Official(s) to Contact Regarding Self-Insurance:

	Name	Title	Address	E-Mail	Phone No.
1					
2					

Company Official(s) to Contact Regarding Montana Operations:

	Name	Title	Address	E-Mail	Phone No.
1					
2					

ACCIDENT AND CLAIM SUMMARY

Claims reported on: ____ Policy Year ____ Fiscal Year ____ Calendar Year

Claim year: beginning date _____/_____/_____ ending date _____/_____/_____
mm / dd / yyyy mm / dd / yyyy

ACCIDENTS BY YEAR:	**2009**	**2008**	**2007**	**2006**	**2005**
# Medical Only					
# Lost Time					
# Fatal					
Total Accidents					

	← All Claims Open & Closed →					**Open Claims Only**
All CLAIMS BY YEAR	**2009**	**2008**	**2007**	**2006**	**2005**	**For Years Prior to 2005**
Total payments made: (line 1)						
Unpaid reserves, without IBNR, as of end of most recent Year: (line 2)						
Total Incurred liability, without IBNR, updated as of most recent year-end: (line 1 + line 2)						
Expected recoveries from excess insurance carrier						

When were Reserves last updated? _____ By whom? _____
(Date) (Company)

Three-Year Average Incurred Liability (Use 2008, 2007, 2006): $ _____

Undiscounted Total Estimated UNPAID Liability On All Montana Claims:

For Claims incurred before 7/1/1989	$
For Claims incurred after 7/1/1989	$
Total Claims (sum of line 2 above)	$

Total Cash Paid During the *Last Calendar Year* (1/1/2009 - 12/31/2009):
Indemnity $ _____+ Medical $ _____+ Other $ _____ = Total $ _____

Medical payments in excess of $200,000 per claim during last calendar year $ _____

Are estimated unpaid compensation and medical liabilities included on company balance sheet? ___Yes ___No

If yes, how are they classified? _____
If no, explain. _____

Do you have a formal safety program? _____ Yes _____No
Is there a Safety Engineer at Montana locations? _____Yes _____No

CLAIMS EXAMINER INFORMATION

Name of Montana Examiner_____ Phone_____
Address_____
E-Mail _____
Location of Montana Claim Files _____
Third Party Administrator_____
(if applicable)

SECURITY & EXCESS INSURANCE INFORMATION

Surety Bond:
Name of Surety Company_____Phone_____
Address_____
Bond Amount $_____ Effective Date_____

Letter of Credit:
Name of Bank_____Phone_____
Address_____
LOC Amount $_____ Effective Date_____

Government Bond/Security:
Type of Bond/Security_____
Interest %_____ Maturity Date_____ Cusip #_____
Bond Amount $_____ Effective Date_____

Certificate(s) of Deposit:
Name of Bank(s)_____, _____, _____
Certificate Number(s)_____, _____, _____
CD Amount(s) $_____, $_____, $_____

Specific Excess Insurance:
Name of Insurance Carrier_____
Effective Date_____ Expiration Date_____
Self-Insured Retention (SIR) $_____ Policy Limit $_____
Deductable $_____

Aggregate Excess Insurance:
Name of Insurance Carrier_____
Effective Date_____ Expiration Date_____
Self-Insured Retention (SIR) $_____ Policy Limit $_____

ELECTION AND CERTIFICATION

We hereby make application to be a self-insured employer in Montana and certify that all of the information provided is correct. Our firm is an employer in the State of Montana. If we are granted self-insured status by the Department, we agree to comply with and be bound by all of the applicable laws, rules, and regulations of Montana pertaining to workers' compensation and occupational disease.

We agree to notify the Department of Labor & Industry and the Montana Self-Insurers Guaranty Fund within 24 hours of the filing of any bankruptcy or determination of insolvency relating to this firm.

This election is made by the firm and authorized by the directors, officials, officers, by-laws, owners, or partners.

Typed Name	Title	Phone	Date

Authorized Signature

Typed Name	Title	Phone	Date

Authorized Signature

Montana Workers' Compensation Self-Insurance Application for 2010
Supplement Page